Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

JACOB ROSENSTEIN MD
800 WEST ARBROOK BLVD SUITE 150
ARLINGTON TX 76015

Respondent Name
AMERICAN HOME ASSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-08-2233-01

MFDR Date Received
DECEMBER 4, 2007

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated November 30, 2007: "Code 22630-51 for $1,795.28 for the posterior lumbar interbody fusion L5-S1 was denied stating, 'exceeds fee schedule'. This is incorrect as this code was billed correctly according to the medical fee guidelines and is not global according to the National Correct Manuel Version 13.1 and is necessary to this operation. The MAR for this code is $1,795.28 and half is **$897.64 which is still due**." "Code 22325-51 for $1,595.10 for the open reduction L2-S1 spondylolisthesis was denied stating, 'exceeds fee schedule.' This is not correct as this code as billed correctly according to the medical fee guidelines and is well documented on page 4 of the operative report enclosed. It describes in detail how this was performed on the patient. The MAR for this code is $1,595.10 and since it was billed with a -51 modifier, **$797.55 is still due**". "Code 63012 for $1,358.29 for the L5 Gill type decompressive laminectomy was denied stating, 'global.' This is incorrect as this code is not global according to the National Correct Coding Manuel Version 13.1. The MAR for this code is **$1,358.29 and is still due**". "Code 22842 for $958.15 for the posterior instrumentation of the lumbar spine L5-S1 was reduced by half stating 'exceeds fee schedule.' This is incorrect as this was billed correctly according to the fee guidelines…an additional **$479.07 is still due**." "Code 22851 for $508.63 for the placement of pioneer peek interbody fusion cages L5-S1 was denied stating, 'exceeds fee schedule.' This is incorrect as this code was billed correctly according to the fee guidelines. The MAR for this code is **$508.63 and is still due**". "Code 20938 for $229.51 for the right iliac osteotomy was reduced by half stating, 'exceeds fee schedule.' This is incorrect as this code was billed correctly according to the fee guidelines and is not subject to the multiple procedure rule, therefore it does not get a 50% payment reduction. The MAR for this code is $229.51 and since $114.76 was reimbursed, and additional **$114.75 is still due**".

Requestor's Supplemental Position Summary Dated December 9, 2008: "Will you please withdraw all the DOP codes for example 20936, 27299, 63048, and 90779 on all pending active disputes we have with your office."

Requestor's Supplemental Position Summary Dated December 15, 2008: "yes 63044 is a DOP code and we don't with to pursue this one either. I forgot to inclue this in my email to you so if you need me to email another statement w/this added in I will. So if any dispute includes 63044, I need to withdraw this code 63044".

Amount in Dispute: $4,155.93

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated December 21, 2007: "The Requestor performed several surgical procedures on the Claimant on June 29, 2007. Upon receipt of the medical bill, the Carrier sent the bill and the documentation to a nurse manager for review. The nurse opined that the Provider billed for two posterior fusion codes which appeared to be a duplication. Therefore, one code, 22630-51 billed at $1,795.28 was denied. The

CPT code 22325, open treatment of a fracture, appead to be included in other surgical procedures billed, and therefore, it was also denied….Additionally, CPT code 22851, application of biomechanical devices also appeared to be included in other surgical procedures billed, and was therefore denied. All other charges were paid according to the fee guidelines and multiple surgery procedures."

Response Submitted by: Downs Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 29, 2007	CPT Code 22630-51	$897.64	$897.63
	CPT Code 22325-51	$797.55	$797.55
	CPT Code 63012	$1358.29	$0.00
	CPT Code 22842	$479.07	$479.07
	CPT Code 22851	$508.63	$508.62
	CPT Code 20938	$114.75	$114.75
TOTAL		$4,155.93	$2,797.62

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.202, effective August 1, 2003, sets the reimbursement guidelines for the disputed services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated August 10, 2007
   - ADL-Services have been reviewed without consideration of the ADL status.
   - NSR-Recommended allowance is based on an Intracorp Nurse Review.
   - 051—51 indicates multiple procedure charges exceed our fee schedule or maximum allowable amount.
   - NCC-This procedure/service is not paid separately payment is included in the allowance for another service/procedure.
   - 203-Disallowed; included in another procedure/service.
   - NPS-This bill has been screened by an Intracorp nurse and charges are found appropriate.
   - 701-Reduced in accordance with multiple procedure guidelines.
   - 225-Disallowed; services included in the listed value of the surgical procedure.
   - 026-Professional component.

   Explanation of benefits dated August 10, 2007
   - 97-Payment is included in the allowance for another service/procedure.
   - 42-Charges exceed our fee schedule or maximum allowable amount.

   Explanation of benefits dated November 7, 2007
   - 537-Recommendation(s0 wills tand as they were previously defined and no addl recommendation is due based on the DWC medical fee guideline/rules. No additional reimbursement allowed after review of appeal/reconsideration.
   - 051—51 indicates multiple procedures.
   - 026-Professional component.

   Explanation of benefits dated November 7, 2007

- W4-No additional reimbursement allowed after review of appeal/reconsideration.

Issues

1. Is the requestor entitled to reimbursement for CPT code 22630-51?
2. Is the requestor entitled to reimbursement for CPT code 22325-51?
3. Is the requestor entitled to reimbursement for CPT code 63012?
4. Is the requestor entitled to reimbursement for CPT code 22842?
5. Is the requestor entitled to reimbursement for CPT code 22851?
6. Is the requestor entitled to reimbursement for CPT code 20938?

Findings

1. 28 Texas Administrative Code §134.202(b) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section."

   On the disputed date of service the requestor billed codes 20936, 27299-51, 22612, 63012, 22842, 22851, 38230-51, 20938, 22630-51, 22325-51, and 77002-26, .

   CPT code 22630-51 is defined as "Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar".

   According to the explanation of benefits, CPT code 22630 was paid based upon reason codes "42".

   The requestor states in the position summary that "Code 22630-51 for $1,795.28 for the posterior lumbar interbody fusion L5-S1 was denied stating, 'exceeds fee schedule'. This is incorrect as this code was billed correctly according to the medical fee guidelines and is not global according to the National Correct Manuel Version 13.1 and is necessary to this operation. The MAR for this code is $1,795.28 and half is $**897.64 which is still due**."

   The respondent states in the position summary that "The nurse opined that the Provider billed for two posterior fusion codes which appeared to be a duplication. Therefore, one code, 22630-51 billed at $1,795.28 was denied."

   A review of the operative report indicates "Posterior lumbar interbody fusion"; therefore, the documentation supports billing of 22630.

   Per Rule 134.202(b), the maximum allowable reimbursement, (MAR) is determined by locality. A review of Box 32 on CMS-1500 indicates that the zip code 76017 is the locality. This zip code is located in Tarrant County.

   28 Texas Administrative Code §134.202(c)(1) states "To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: "for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%."

   The Medicare allowable for CPT code 22630-51 in Tarrant County is $1,436.22. Per 28 Texas Administrative Code §134.202(c)(1) this amount is multiplied by 125% equals a MAR of $1,795.27. This code is subject to multiple procedure rule discounting of 50%; therefore, the MAR is $897.63. The difference between the MAR and amount paid is $897.63. As a result, the amount ordered is $897.63.

2. CPT code 22325-51-51 is defined as "Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, 1 fractured vertebra or dislocated segment; lumbar."

   According to the explanation of benefits, CPT code 22325-51 was denied payment based upon reason code "42".

   The requestor states in the position summary that "Code 22325-51 for $1,595.10 for the open reduction L2-S1 spondylolisthesis was denied stating, 'exceeds fee schedule.' This is not correct as this code as billed correctly according to the medical fee guidelines and is well documented on page 4 of the operative report

enclosed. It describes in detail how this was performed on the patient. The MAR for this code is $1,595.10 and since it was billed with a -51 modifier, **$797.55 is still due**".

The respondent states in the position summary that "The CPT code 22325, open treatment of a fracture, appead to be included in other surgical procedures billed, and therefore, it was also denied."

According to the operative report the claimant underwent "Open reduction of L5-S1 anterolisthesis"; therefore, the requestor has supported billing of code 22325-51.

The Medicare allowable for CPT code 22325-51 in Tarrant County is $1,276.08. Per 28 Texas Administrative Code §134.202(c)(1) this amount is multiplied by 125% equals a MAR of $1,595.10. This code is subject to multiple procedure rule discounting of 50%; therefore, the MAR is $797.55. The difference between the MAR and amount paid is $797.55. As a result, the amount ordered is $797.55.

3. CPT code 63012 is defined as "Laminectomy with removal of abnormal facets and/or pars inter-articularis with decompression of cauda equina and nerve roots for spondylolisthesis, lumbar (Gill type procedure)".

   The respondent denied reimbursement for CPT code 63012 based upon reason code "97"

   The requestor states in the position summary that "Code 63012 for $1,358.29 for the L5 Gill type decompressive laminectomy was denied stating, 'global.' This is incorrect as this code is not global according to the National Correct Coding Manuel Version 13.1. The MAR for this code is $**1,358.29 and is still due**".

   Per CCI edits, CPT code 63012 is a component of CPT code 22630, the use of a modifier is allowed to differentiate the service. A review of the submitted medical bill finds that the requestor did not use a modifier; therefore, CPT code 63012 is unbundled. As a result, reimbursement cannot be recommended.

4. CPT code 22842 is defined as "Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code for primary procedure)."

   According to the explanation of benefits the respondent reduced payment for CPT code 22842 based upon reason codes "42".

   The requestor states in the position summary that "Code 22842 for $958.15 for the posterior instrumentation of the lumbar spine L5-S1 was reduced by half stating 'exceeds fee schedule.' This is incorrect as this was billed correctly according to the fee guidelines…an additional **$479.07 is still due.** "

   The Medicare allowable for CPT code 22842 in Tarrant County is $766.52. Per 28 Texas Administrative Code §134.202(c)(1) this amount is multiplied by 125% equals a MAR of $958.15. This code is not subject to multiple procedure rule discounting; therefore, the MAR is $958.15. The difference between the MAR and amount paid is $479.07. As a result, the amount ordered is $479.07.

5. CPT code 22851 is defined as "Application of intervertebral biomechanical device(s) (eg, synthetic cage(s), methylmethacrylate) to vertebral defect or interspace (List separately in addition to code for primary procedure)."

   The respondent denied reimbursement for CPT code 22851 utilizing reason code "42".

   The requestor states in the position summary that "Code 22851 for $508.63 for the placement of pioneer peek interbody fusion cages L5-S1 was denied stating, 'exceeds fee schedule.' This is incorrect as this code was billed correctly according to the fee guidelines. The MAR for this code **is $508.63 and is still due**".

   The respondent states in the position summary that "CPT code 22851, application of biomechanical devices also appeared to be included in other surgical procedures billed, and was therefore denied."

   Per CCI Edits, CPT code 22851 is not global to any of the other services billed on this date; therefore, reimbursement per the fee guideline is recommended.

   The Medicare allowable for CPT code 22851 in Tarrant County is $406.90. Per 28 Texas Administrative Code §134.202(c)(1) this amount is multiplied by 125% equals a MAR of $508.62. This code is not subject to multiple procedure rule discounting; therefore, the MAR is $508.62. The difference between the MAR and amount paid is $508.62. As a result, the amount ordered is $508.62.

6. CPT code 20938 is defined as "Autograft for spine surgery only (includes harvesting the graft); structural, bicortical or tricortical (through separate skin or fascial incision) (List separately in addition to code for primary procedure)."

   The respondent denied reimbursement for CPT code 20938 utilizing reason code "42".

   The requestor states in the position summary that "Code 20938 for $229.51 for the right iliac osteotomy was reduced by half stating, 'exceeds fee schedule.' This is incorrect as this code was billed correctly according

to the fee guidelines and is not subject to the multiple procedure rule, therefore it does not get a 50% payment reduction. The MAR for this code is $229.51 and since $114.76 was reimbursed, and additional **$114.75 is still due**".

The Medicare allowable for CPT code 20938 in Tarrant County is $183.61. Per 28 Texas Administrative Code §134.202(c)(1) this amount is multiplied by 125% equals a MAR of $229.51. This code is not subject to multiple procedure rule discounting; therefore, the MAR is $229.51. The difference between the MAR and amount paid is $114.75. As a result, the amount ordered is $114.75.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $ 2,797.62.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $2,797.62 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		1/11/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.